

FILED APR 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8507

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 199 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 1388 | |
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE KANSAS b. COUNTY JOHNSON | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY | | | | c. CITY (If outside corporate limits, write RURAL and give township) MISSION | | | |
| c. LENGTH OF STAY (in this place) 3 days | | | | d. STREET ADDRESS (If rural, give location) 5628 NALL AVENUE | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) WILLIAM | | b. (Middle) HENRY | | c. (Last) BEAUMONT | |
| 4. DATE OF DEATH | | (Month) (Day) (Year) | | MAR. 23. 1950 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 1 HRS. | |
| MALE | WHITE | WIDOWED | JULY-19-1864 | 66 YEARS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RETIRED BYAL OWNER OPERATOR BEAUMONT & CO. | | W. H. | | NEW YORK, N. Y. | | U. S. A. | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | | |
| BEAUMONT | | UNKNOWN | | SARAH BEAUMONT | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME | | ADDRESS | |
| NO | | 491-227861 | | MR. WILLIAM N. BEAUMONT | | 6005 REEDS ROAD | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | | |
| ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension | | | | | | | |
| DUE TO (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 331X | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Sept 1944 to March 1950, that I last saw the deceased alive on March 1950, and that death occurred at 8:07 A. M., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE K. W. Carbaugh (Degree or title) MD | | | | 23b. ADDRESS Mission, Kans | | 23c. DATE SIGNED 23 March 50 | |
| 24a. BURIAL, CREMATION, REMOVAL | | 24b. DATE | | 24c. NAME OF CREMATOR OR CREMATORY | | 24d. LOCATION (City, town, or county) (State) | |
| CREMATION | | MAR. 26, 1950 | | D. W. NEWCOMER'S | | KANSAS CITY, MO | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| 3-25-50 | | Geraldine Holmes | | D. W. Newcomer's Sons | | 1331 BRUSH CREEK KANSAS CITY, MO. | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

working under my personal supervision.

Student Embalmer No.

Signed_____

Edward M. Storey

Signed.....
Student Embalmer

Licensed Embalmer No. *44520*

P. O. Address *K. C. 4 Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.